STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G464	A. BUILDING 00 B. WING	04/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	2414 WOODLANE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for the investigation of Complaint #IN00106203. COMPLAINT #IN00106203: SUBSTANTIATED, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W124, W149, W153, and W159. Dates of survey: April 16, 17, and 18, 2012 Facility number: 000978 Provider number: 15G464 AIM number: 100249370 Surveyor: Tim Shebel, Medical Surveyor III The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed on April 19, 2012 by Dotty Walton, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview, the Condition of Participation of Governing Body and Management is not met as the facility's governing body failed to implement policies and procedures to assure 1 of 3 sampled client's (client A's) hygiene and personal needs were timely addressed by Direct Care Staff and the Service Coordinator (Qualified Mental Retardation Professional.) Findings include: 1. Please refer to W104 as the facility's governing body failed to implement policies and procedures to address the Direct Care Staff and the Service Coordinator in providing, monitoring, and coordinating timely care of 1 of 3 sampled client's hygiene and personal needs (client A). This federal tag relates to complaint #IN00106203. 9-3-1(a)	W0102	Staff will be retrained on assisting with client's hygiene and care. Should an issue arise, staff is to notify Service Coordinator immediately. Service Coordinator will then take the necessary actions to make sure the issue is taken care of in a timely manner. To ensure future compliance, Service Coordinator will make random visits to observe hygiene practices at least monthly.	05/01/2012

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W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, the facility's governing body failed to implement policies and procedures which addressed the Direct Care Staff and the Service Coordinator (Qualified Mental Retardation Professional) in providing, monitoring, and coordinating timely care of 1 of 3 sampled client's hygiene and personal needs (client A). Findings include: A review of the facility's incident reports on 4/16/12 at 9:52 A.M., from 3/1/12 to 4/16/12, indicated the following incident of neglect which involved client A: "Date: 3/26/2012, Name: [Client A], Narrative: [Client A's] sister visited [client A] on 3/25/12 and discovered bruises on her (client A's) body; feces under her fingernails; extremely dry skin; and toe nails so long they were upturned. Staff (direct care staff) said that she (client A) has an appointment with the podiatrist once in every six months but the guardian does not have any records of a podiatry appointment. Plan to Resolve: Agency will take immediate safety measures to ensure [client A's] health and safety."	W0104	All incidents are to be reported within 24 hours. Staff will be retrained on all incident reporting procedures. To ensure future compliance, Service Coordinator will monitor all incident reports for completion. Phone calls will be made weekly to group home to inquire about any incidents for the past week.	05/01/2012

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	The facility's records were further reviewed on 4/16/12 at 10:10 A.M.. The facility's investigative report of the 3/25/12 incident report indicated the following: "Investigation was conducted by the agency. All staff was (sic.) immediately removed from the home pending the results of the investigation and replacement staff trained and put into place at the home. The results of the investigation are as follows: [Client A's] family (sister's who are co-guardians of client A) took pictures on Sunday March 25, 2012 at 1:30 pm of a mark on [client A's] body. We (the facility) received them (pictures) on Monday March 26, 2012 at 8:15 pm via email. Two separate head to toe assessments were performed by the nurse & the Director of Health Services-RN. Both nurses stated in the investigation and upon follow-up with the department head that there was no swelling of the hands noticed, nor was a bruise noted on [client A's] abdomen. The only skin discoloration noted was an approximate dime size very light pink area to her (client A's) lower buttock. [Client A] was then assessed by the doctor. The doctor did not notice any injuries or swelling at the time of visit. Additional pictures of long toe nails and dirty finger nails were also included. The family cut [client A's] toe nails and			

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	cleaned her finger nails at about 8:30 pm on Sunday 3/25/12. Risk plans will also be in place for care of nails for the consumer. The investigation was concluded and the allegation substantiated. Discipline was rendered, four staff had direct knowledge of [client A's] toe nails and their employment at the [Agency] was terminated. The remaining staff did not work shifts which involved bathing or dressing and had no direct knowledge of the condition of [client A's] toe nails or the pink dime size mark but will receive additional training in regards to client needs and care. New staff are in place and being trained to work with [client A.] [Client A] also visited a podiatrist whom indicated that there was no damage caused by [client A's] feet from her long toe nails." The facility's records were further reviewed on 4/16/12 at 10:22 A.M.. Evidence from the 3/30/12 investigation indicated photographs of client A's body, which were taken by client A's guardian on 3/25/12 and forwarded to the facility. Review of the photographs indicated dirt under client A's fingernails which was determined to be feces. Client A's toe nails were noted to be of varied length from one-half inch to an inch and were upturned. A dime size pink mark was noted on client A's buttocks and a pencil			

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	eraser size dark blue blood blister was noted on a fingernail. Facility records were further reviewed on 4/16/12 at 10:31 A.M.. Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the dirt under the client's finger nails to be "uncommon." Further review indicated direct care staff did not immediately report the dime size pink mark on client A's buttocks and the pencil eraser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's family told the facility's Service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any action to have client A's toe nails trimmed and did not report the noted pink mark on the client's buttocks or the blood blister on the client's finger to the administrator until approached by the facility's administration on 3/27/12.			

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	Nurse #1 was interviewed on 4/17/12 at 9:12 A.M.. Nurse #1 stated client A's toe nails "were so long that she (client A) curled her toes down so she could wear her shoes." Program Director #1 was interviewed on 4/17/12 at 9:15 A.M.. Program Director #1 stated, "Four direct care staff and the Service Coordinator were found guilty of neglect and where terminated." Program Director #1 stated direct care staff and the Service Coordinator "should have provided appropriate care to [client A] and should have reported the pink mark and the blood blister immediately to the administrator. As an agency we train and re-train staff to take care of our clients in appropriate ways. We expect and trust them to do their jobs. It isn't always easy to determine when they aren't." This federal tag relates to complaint #IN00106203. 9-3-1(a)			

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W0122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the Condition of Participation of Client Protections is not met as the facility failed to: 1. Notify the guardian of 1 of 2 sampled clients with a guardian (client A) of impending appointments for treatment; 2. Implement it's abuse/neglect policy to assure the personal needs of 1 of 3 sampled clients (client A) were addressed, and, 2. Implement it's abuse/neglect policy to 1 of 1 reviewed incident of injuries of unknown origin involving 1 of 3 sampled clients (client A) were immediately reported to the administrator; and, 3. Assure the Service Coordinator (Qualified Mental Retardation Professional) monitored and coordinated timely care for 1 of 3 sampled clients (client A's) hygiene, personal, and medical needs. Findings include: 1. Please refer to W124 as the facility failed to notify 1 of 2 sampled clients with a guardian (client A) of impending medical appointments. 2. Please refer to W149 as the facility neglected to implement it's abuse/neglect	W0122	All incidents of abuse, neglect, or exploitation will be reported within 24 hours. To ensure future compliance, Service Coordinator will make random visits to the house at least twice monthly to observe hygiene practices, and to ensure client's needs are being met.	05/01/2012

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	policy to assure the personal needs of 1 of 3 sampled clients (client A) were addressed and immediately notify the administrator of 1 of 1 reviewed incident of injuries of unknown origin involving 1 of 3 sampled clients (client A.) 3. Please refer to W153 as the facility failed to implement it's abuse/neglect policy to 1 of 1 reviewed incident of injuries of unknown origin involving 1 of 3 sampled clients (client A) were immediately reported to the administrator. 4. Please refer to W159 as the facility failed to assure the Service Coordinator (Qualified Mental Retardation Professional) monitored and coordinated timely care for 1 of 3 sampled clients (client A's) hygiene, personal, and medical needs. This federal tag relates to complaint #IN00106203. 9-3-2(a)			

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W0124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. Based on record review and interview, the facility failed to notify 1 of 2 sampled clients with a guardian (client A) of impending medical appointments. Findings include: Client A's record was reviewed on 4/16/12 at 10:10 A.M.. A review of the client's cumulative medical record indicated the client attended an appointment with her primary care physician on 3/26/12 and attended a podiatrist appointment on 4/3/12. The review further indicated client A had a legal co-guardianship which were the client's sisters. Program Director #1 was interviewed on 4/17/12 at 9:15 A.M.. When asked if client A's guardians had been informed of the primary care physician and Podiatrist appointments, Program Director #1 stated, "No." This federal tag relates to complaint	W0124	Service Coordinator will notify all clients and their legal guardians of any changes in physical, medical, and behavioral condition. To ensure future compliance, Service Coordinator will visit clients weekly, and will make contact with the legal guardians at least monthly.	05/01/2012

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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility neglected to implement it's abuse/neglect policy to assure the personal needs of 1 of 3 sampled clients (client A) were addressed and to immediately notify the administrator of 1 of 1 reviewed incident of injuries of unknown origin involving 1 of 3 sampled clients (client A.) Findings include: A review of the facility's incident reports on 4/16/12 at 9:52 A.M., from 3/1/12 to 4/16/12, indicated the following incident of neglect which involved client A: "Date: 3/26/2012, Name: [Client A], Narrative: [Client A's] sister visited [client A] on 3/25/12 and discovered bruises on her (client A's) body; feces under her fingernails; extremely dry skin; and toe nails so long they were upturned. Staff (direct care staff) said that she (client A) has an appointment with the podiatrist once in every six months but the guardian does not have any records of a podiatry appointment. Plan to Resolve: Agency will take immediate safety measures to ensure [client A's] health and safety."	W0149	The agency policy for Abuse, Neglect, and Exploitation will be followed at all times. To ensure future compliance, Service Coordinator will report any incidences that could be considered abuse, neglect, or exploitation to Residential Program Director.	05/01/2012

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	The facility's records were further reviewed on 4/16/12 at 10:10 A.M.. The facility's investigative report of the 3/25/12 incident report indicated the following: "Investigation was conducted by the agency. All staff was (sic.) immediately removed from the home pending the results of the investigation and replacement staff trained and put into place at the home. The results of the investigation are as follows: [Client A's] family (sister's who are co-guardians of client A) took pictures on Sunday March 25, 2012 at 1:30 pm of a mark on [client A's] body. We (the facility) received them (pictures) on Monday March 26, 2012 at 8:15 pm via email. Two separate head to toe assessments were performed by the nurse & the Director of Health Services-RN. Both nurses stated in the investigation and upon follow-up with the department head that there was no swelling of the hands noticed, nor was a bruise noted on [client A's] abdomen. The only skin discoloration noted was an approximate dime size very light pink area to her (client A's) lower buttock. [Client A] was then assessed by the doctor. The doctor did not notice any injuries or swelling at the time of visit. Additional pictures of long toe nails and dirty finger nails were also included. The family cut [client A's] toe nails and			

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	cleaned her finger nails at about 8:30 pm on Sunday 3/25/12. Risk plans will also be in place for care of nails for the consumer. The investigation was concluded and the allegation substantiated. Discipline was rendered, four staff had direct knowledge of [client A's] toe nails and their employment at the [Agency] was terminated. The remaining staff did not work shifts which involved bathing or dressing and had no direct knowledge if the condition of [client A's] toe nails or the pink dime size mark but will receive additional training in regards to client needs and care. New staff are in place and being trained to work with [client A.] [Client A] also visited a podiatrist whom indicated that there was no damage caused by [client A's] feet from her long toe nails." The facility's records were further reviewed on 4/16/12 at 10:22 A.M.. Evidence from the 3/30/12 investigation indicated photographs of client A's body, which were taken by client A's guardian on 3/25/12 and forwarded to the facility. Review of the photographs indicated dirt under client A's fingernails which was determined to be feces. Client A's toe nails were noted to be of varied length from one-half inch to an inch and were upturned. A dime size pink mark was noted on client A's buttocks and a pencil			

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	eraser size dark blue blood blister was noted on a fingernail. Facility records were further reviewed on 4/16/12 at 10:31 A.M.. Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the dirt under the client's finger nails to be "uncommon." Further review indicated direct care staff did not immediately report the dime size pink mark on client A's buttocks and the pencil eraser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's family told the facility's Service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any action to have client A's toe nails trimmed and did not report the noted pink mark on the client's buttocks or the blood blister on the client's finger to the administrator until approached by the facility's administration on 3/27/12.			

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	15G464	A. BUILDING 00 B. WING	04/18/2012

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	Nurse #1 was interviewed on 4/17/12 at 9:12 A.M.. Nurse #1 stated client A's toe nails "were so long that she (client A) curled her toes down so she could wear her shoes." Program Director #1 was interviewed on 4/17/12 at 9:15 A.M.. Program Director #1 stated, "Four direct care staff and the Service Coordinator were found guilty of neglect and where terminated." Program Director #1 stated direct care staff "should have reported the pink mark and the blood blister immediately to the administrator." The facility's records were further reviewed on 4/18/12 at 9:14 A.M.. A review of the facility's "Policy for handling Cases of Neglect and Abuse", dated 12/20/06, indicated, in part, the following: "I. [The Agency] prohibits all abuse, neglect and exploitation of our clients. II. Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure. [The Agency] will meet current regulatory requirements for reporting all incidents. III. All allegations of abuse, neglect, humiliation or exploitation will be investigated per [The Agency] investigation process." The policy further indicated, "Neglect- is defined as knowingly placing a client in a			

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	situation that poses a threat to his/her health and well-being. Examples include, but are not limited to, depriving a client of food, clothing, shelter or medical care; not providing adequate personal care, leaving clients unsupervised, etc." This federal tag relates to complaint #IN00106203. 9-3-2(a)			

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W0153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed to ensure, for 1 of 1 reviewed incident of injuries of unknown origin involving 1 of 3 sampled clients (client A), were immediately reported to the administrator. Findings include: A review of the facility's incident reports on 4/16/12 at 9:52 A.M., from 3/1/12 to 4/16/12, indicated the following incident of neglect which involved client A: "Date: 3/26/2012, Name: [Client A], Narrative: [Client A's] sister visited [client A] on 3/25/12 and discovered bruises on her (client A's) body; feces under her fingernails; extremely dry skin; and toe nails so long they were upturned. Staff (direct care staff) said that she (client A) has an appointment with the podiatrist once in every six months but the guardian does not have any records of a podiatry appointment. Plan to Resolve: Agency will take immediate safety measures to ensure [client A's] health and safety."	W0153	Residential Program Director will review requirements of abuse, neglect and exploitation of clients with Service Coordinators and DSPs and document this review with regards to the 24 hour requirement. To ensure future compliance, the Service Coordinator, with the assistance of the Residential Program Director, will review all incident reports for this facility for one month to assess need for reporting and periodically thereafter.	05/01/2012

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	The facility's records were further reviewed on 4/16/12 at 10:10 A.M.. The facility's investigative report of the 3/25/12 incident report indicated the following: "Investigation was conducted by the agency. All staff was (sic.) immediately removed from the home pending the results of the investigation and replacement staff trained and put into place at the home. The results of the investigation are as follows: [Client A's] family (sister's who are co-guardians of client A) took pictures on Sunday March 25, 2012 at 1:30 pm of a mark on [client A's] body. We (the facility) received them (pictures) on Monday March 26, 2012 at 8:15 pm via email. Two separate head to toe assessments were performed by the nurse & the Director of Health Services-RN. Both nurses stated in the investigation and upon follow-up with the department head that there was no swelling of the hands noticed, nor was a bruise noted on [client A's] abdomen. The only skin discoloration noted was an approximate dime size very light pink area to her (client A's) lower buttock. [Client A] was then assessed by the doctor. The doctor did not notice any injuries or swelling at the time of visit. Additional pictures of long toe nails and dirty finger nails were also included. The family cut [client A's] toe nails and			

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	cleaned her finger nails at about 8:30 pm on Sunday 3/25/12. Risk plans will also be in place for care of nails for the consumer. The investigation was concluded and the allegation substantiated. Discipline was rendered, four staff had direct knowledge of [client A's] toe nails and their employment at the [Agency] was terminated. The remaining staff did not work shifts which involved bathing or dressing and had no direct knowledge if the condition of [client A's] toe nails or the pink dime size mark but will receive additional training in regards to client needs and care. New staff are in place and being trained to work with [client A.] [Client A] also visited a podiatrist whom indicated that there was no damage caused by [client A's] feet from her long toe nails." The facility's records were further reviewed on 4/16/12 at 10:22 A.M.. Evidence from the 3/30/12 investigation indicated photographs of client A's body, which were taken by client A's guardian on 3/25/12 and forwarded to the facility. Review of the photographs indicated dirt under client A's fingernails which was determined to be feces. Client A's toe nails were noted to be of varied length from one-half inch to an inch and were upturned. A dime size pink mark was noted on client A's buttocks and a pencil			

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	eraser size dark blue blood blister was noted on a fingernail. Facility records were further reviewed on 4/16/12 at 10:31 A.M.. Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the dirt under the client's finger nails to be "uncommon." Further review indicated direct care staff did not immediately report the dime size pink mark on client A's buttocks and the pencil eraser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's family told the facility's Service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any action to have client A's toe nails trimmed and did not report the noted pink mark on the client's buttocks or the blood blister on the client's finger to the administrator until approached by the facility's administration on 3/27/12.			

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	Program Director #1 was interviewed on 4/17/12 at 9:15 A.M.. Program Director #1 stated, "Four direct care staff and the Service Coordinator were found guilty of neglect and where terminated." Program Director #1 stated direct care staff and the Service Coordinator "should have reported the pink mark and the blood blister immediately to the administrator." This federal tag relates to complaint #IN00106203. 9-3-2(a)			

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W0159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview, the facility failed to assure the Service Coordinator (Qualified Mental Retardation Professional) monitored and coordinated timely care for 1 of 3 sampled clients (client A's) hygiene, personal, and medical needs. Findings include: A review of the facility's incident reports on 4/16/12 at 9:52 A.M., from 3/1/12 to 4/16/12, indicated the following incident of neglect which involved client A: "Date: 3/26/2012, Name: [Client A], Narrative: [Client A's] sister visited [client A] on 3/25/12 and discovered bruises on her (client A's) body; feces under her fingernails; extremely dry skin; and toe nails so long they were upturned. Staff (direct care staff) said that she (client A) has an appointment with the podiatrist once in every six months but the guardian does not have any records of a podiatry appointment. Plan to Resolve: Agency will take immediate safety measures to ensure [client A's] health and safety." The facility's records were further reviewed on 4/16/12 at 10:10 A.M.. The facility's investigative report of the 3/25/12 incident report indicated the following: "Investigation was conducted by the agency. All staff was (sic.) immediately removed from the home pending the results of the investigation and replacement staff trained and put into place at the home. The results of the investigation are as follows: [Client A's] family (sister's who are co-guardians of client A) took pictures on Sunday March 25, 2012 at 1:30 pm of	W0159	A new Service Coordinator has been assigned. Service Coordinator will be actively involved in treatment through daily review of logs, weekly visits, and at least monthly review of data. To ensure future compliance, Service Coordinator will make random unannounced visits to the home to review programming and to ensure clients' needs are being met.	05/01/2012

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	a mark on [client A's] body. We (the facility) received them (pictures) on Monday March 26, 2012 at 8:15 pm via email. Two separate head to toe assessments were performed by the nurse & the Director of Health Services-RN. Both nurses stated in the investigation and upon follow-up with the department head that there was no swelling of the hands noticed, nor was a bruise noted on [client A's] abdomen. The only skin discoloration noted was an approximate dime size very light pink area to her (client A's) lower buttock. [Client A] was then assessed by the doctor. The doctor did not notice any injuries or swelling at the time of visit. Additional pictures of long toe nails and dirty finger nails were also included. The family cut [client A's] toe nails and cleaned her finger nails at about 8:30 pm on Sunday 3/25/12. Risk plans will also be in place for care of nails for the consumer. The investigation was concluded and the allegation substantiated. Discipline was rendered, four staff had direct knowledge of [client A's] toe nails and their employment at the[Agency] was terminated. The remaining staff did not work shifts which involved bathing or dressing and had no direct knowledge of the condition of [client A's] toe nails or the pink dime size mark but will receive additional training in regards to client needs and care. New staff are in place and being trained to work with [client A.] [Client A] also visited a podiatrist whom indicated that there was no damage caused by [client A's] feet from her long toe nails." The facility's records were further reviewed on 4/16/12 at 10:22 A.M.. Evidence from the 3/30/12 investigation indicated photographs of client A's body, which were taken by client A's guardian on 3/25/12 and forwarded to the facility. Review of the photographs indicated dirt under client A's fingernails which was determined to be feces. Client A's toe nails were noted to be of			

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